Exhibit 3 (Part 5)

SAMUEL D. SCHENKER, M.D., L.L.C., D.A.A.P.M.
NEUROLOGIST
DIPLOMATE AMERICAN ACADEMY OF PAIN MANAGEMENT
SPECIALIZING IN MEDICAL AND INTERVENTIONAL PAIN MANAGEMENT
388 LAKEHURST ROAD
TOMS RIVER NEW JERSEY 08755
(732) 341-2822
(732) 341-7087 fax

RE: VANDEVENTER, RALPH
PROGRESS NOTE: 11/20/09

The patient is seen here at this time for evaluation of his history of lumbosacral radiculopathy with associated herniated disc on the right. The patient has done extremely well post injection. He has good range-of-motion with minimal discomfort. At this juncture, the left side demonstrates facet pain at L3-L4, L4-L5 and L5-S1 with limitation of rotation of the torso and associated referred pain into the upper thoracic region. At this time, the patient will be scheduled for L4-L5 facet block the following week.

Samuel D. Schenker, M.D.

SDS/jmv
typed but not proofread
DOC: VANDEVENTER,R8.
DD: 11/20/09
DT: 11/23/09

SAMUEL D. SCHENKER, M.D.
NEUROLOGIST
DIPLOMATE AMERICAN ACADEMY OF PAIN MANAGEMENT
SPECIALIZING IN MEDICAL AND INTERVENTIONAL NEUROLOGY
388 LAKEHURST ROAD
TOMS RIVER NEW JERSEY 08755
(732) 341-2822
(732) 341-7087 fax

Patient's Name: Vandeventer, Ralph

Date of Surgery: 11/25/09

Preoperative Diagnosis: Facet Syndrome

Postoperative Diagnosis: Facet Syndrome

Procedure: Left facet injection under fluoroscopic guidance, L4-5. #1

Anesthesia: Local

Preoperative Note: The patient was made aware of the risks and benefits of the procedure and essentially accepts the conditions.

Operative Note: The patient was brought into the operating theater where he was placed decubitus prone and prepped in the standard sterile fashion.

After good visualization under fluoroscopy, localization of the left L4-5 facet joint was made with 1 cc of 1% Xylocaine and a 25 gauge, 1.5 inch needle. Placement of a 25 gauge, 3.5 inch needle was directed into that localization without any difficulty with L4-5 on the left. An injection of 40 mg of Depo-Medrol, 1 cc of Xylocaine 1% and 1 cc of 0.5% Marcaine was injected into said joint. The needle was extracted, and pressure was applied in that distribution with assistance.

Patient's Name: Vandeventer, Ralph
Performed on: 11/25/09
Page Two

Postoperative: The patient demonstrated a good response to said injection without any untoward effects. The patient demonstrates good cognitive status and is discharged from this office on his own cognizance.

Samuel D. Schenker, M.D.

SDS/jmv
typed but not proofread
DOC: VANDEVENTER,R9.
DT: 11/25/09

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FAX

To: Christin Clark
Fax: 518-880-6610

# of pages including cover sheet: 35
Date: 11/07/09

From: Ralph Van Deventer
Phone: [redacted]
Cell: [redacted]

Re: Case # 74518

Dear Christin,

Please find attached to this fax everything I have received from my doctors that was requested in your letter dated 11/09/09.

If there are any questions or you need anything else, please let me know. You can contact me at the above phone numbers. Thank you.

Sincerely,

ReedGroup

Physician Contact Sheet

Directions – Please FAX to 518-880-6610. If you have any questions, call Reed Group at 866-829-8861.

Claimant Name (Please Print):	WWID#:	Claimant Phone Number:
Ralph R. VanDeventer JR	10900	[redacted]

Physician Contact #1

Physician Name/Specialty:	Physician Phone Number:	Fax Number:
Zulfiqar Rajput PSYCHIATRY	732-202-0622	[redacted]

Street Address:	City:	State:	Zip Code:
1541 Rt. 88 west Suite J	Brick town	NJ	08724

Date of Last Visit (MM/DD/YYYY):	Date of Next Visit (MM/DD/YYYY):
	11/23/09

Physician Contact #2

Physician Name/Specialty:	Physician Phone Number:	Fax Number:
Samuel Schenker Neurologist/Pain Mgt.	732-341-2522	732-341-7087

Street Address:	City:	State:	Zip Code:
388 Lakehurst Rd.	Toms River	NJ	08755

Date of Last Visit (MM/DD/YYYY):	Date of Next Visit (MM/DD/YYYY):
~~10~~ 11/20/09 (9/15/09)	11/25/09

Physician Contact #3

Physician Name/Specialty:	Physician Phone Number:	Fax Number:
Irving Strause Orthopedic	732-229-4333	732-571-1937

Street Address:	City:	State:	Zip Code:
279 Third Ave Suite 504	Long Branch	NJ	07740

Date of Last Visit (MM/DD/YYYY):	Date of Next Visit (MM/DD/YYYY):
9/21/09	12/01/09

[ ] I am no longer disabled - Effective Date: _____ Month _____ Day _____ Year

Name of treating provider providing medical release (Print):_____

ReedGroup

AUTHORIZATION TO DISCLOSE AND USE MEDICAL INFORMATION FOR DISABILITY-RELATED DETERMINATIONS

Claimant's Full Name: Ralph Robert Van Deventer JR Date of Birth: [redacted]

Employer's Name: Johnson & Johnson Social Security Number (last 4 digits only): xxx-xx- 5069

I authorize all doctors, hospitals, other health care providers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out my medical information as explained on this form.

This information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, expenses, coverage or benefits, or my employment, vocation, education, training, or income, relating to my current disability or my ability to work, whether obtained prior to or after the date of this authorization ("Information").

Information may be provided to the following individuals or entities ("Benefit Managers"): the employer named above, Reed Group, their benefit plan or claims administrator(s), their related companies, contractors, investigators, attorneys, and service consultants, health care providers who treat or evaluate me with respect to my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim, to allow them to evaluate, analyze, manage and/or administer my claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program or leave benefit offered by and through my employer ("Benefits Program"), to support, defend, or review any determinations made with respect to the programs and benefits and to give my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim under a Benefits Program, or to run a Benefits Program. The Benefits Managers will tell those receiving the Information that the Information is confidential.

I understand that once my Information is given out as authorized in this form, federal privacy laws may not protect it. Benefits Managers may give Information out again as described in this form.

I understand that this permission lasts twelve (12) months after my claim and all appeals are processed or twelve (12) months after the end of my coverage or benefits under the Benefits Program, whichever is longer, unless the law requires a shorter period. If I change my mind before that time, I can tell Reed Group in writing that I do not want Record Holders or Benefit Managers to share any more information. If I write to stop them from sharing Information, it will not change any actions they took before they receive my letter.

If I do not sign this form, it will not affect how my health care providers treat me. However, if I do not sign, the Benefits Managers may not be able to review my claim and find out whether I am eligible for benefits. This may result in the delay or denial of my request for benefits.

The Information released under this authorization can be sent electronically, by phone or fax, or by mail. I know I can see or request a copy of the records given to the Benefits Managers. I agree that a copy of this form may be treated as a signed original. I understand the terms of this form.

Ralph R Van Deventer 11-23-09

Claimant's or Legal Representative's Signature Date

Legal Representative's Name (If any) Legal Representative's Relationship

The person or entity disclosing the Information is responsible for deciding whether to accept this authorization form and, on acceptance, shall send a copy to the claimant.

Please Fax to Reed Group at 518-880-6610 or Return by Mail to the address listed below

ReedGroup

ATTENDING PHYSICIAN STATEMENT (Page 1 of 2)

NOTE TO PHYSICIAN OR OTHER HEALTH CARE PROVIDER: Your full completion of this form is necessary so that the claimant's application for benefit may be received and processed. Space is available on the reverse side if you wish to amplify your answers.

PLEASE ANSWER ALL QUESTIONS. RETURN FORM TO REED GROUP PROMPTLY. Fax # 518-880-6810

Name of patient Ralph R. VanDeventer Jr. Date of birth [redacted] Mo. Day Year

Employer name Johnson & Johnson (ortho clinical Diagnostics)

1. HISTORY
(a) When did symptoms first appear or accident happen? Mo. 9 Day 8 Year 08
(b) Date patient ceased work because of disability Mo. 9 Day 23 Year 09
(c) Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes" state when and describe:
(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☒ No ☐ Unknown
(e) Names and addresses of other treating physicians:

2. DIAGNOSIS (Including primary and secondary diagnoses or complications)
(a) Diagnosis: DJD Arthritis & Spurs 721.3 Lumbar Spasm 847.2 Degenerative Disc Disease General 7224
(b) Date of last examination Mo. 12 Day 1 Year 09
(c) Subjective symptoms:
(d) Objective findings: Your patient may be covered under the Long Term Disability (LTD) provisions of the Johnson and Johnson Plan. To assist Reed Group in making this difficult determination, we request your cooperation in forwarding the yield of objective tests already taken (for example, electrocardiograms, angiograms, etc. for a heart condition; vital capacity readings for emphysema; x-rays for muscular skeletal disorders) and the results found through the use of other clinical techniques.
Do you wish this information returned? ☐ Yes ☒ No

3. DATES OF TREATMENT
(a) Date of first visit Mo. 9 Day 8 20 08
(b) Date of last visit Mo. 12 Day 1 20 09
(c) Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify)

4. NATURE OF TREATMENT (Including surgery and medications prescribed, if any)
Pain management & physical therapy

5. PROGRESS
(a) Has patient ☐ Recovered? ☐ Improved? ☒ Unchanged? ☐ Retrogressed?
(b) Is patient ☒ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?
(c) Has patient been hospital confined? ☐ Yes ☒ No
If "Yes," give Name and Address of Hospital
Continued from through

6. CARDIAC (If applicable)
(a) Functional capacity ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
(American Heart Ass'n.) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)
(b) Blood Pressure (last visit) / SYSTOLIC DIASTOLIC

ReedGroup

ATTENDING PHYSICIAN STATEMENT (Page 2 of 2)

7. PHYSICAL IMPAIRMENT

- ☐ Class 1 — No limitation of functional capacity; capable of heavy physical activity. No restrictions. (0-10%)
- ☐ Class 2 — Slight limitation of functional capacity; capable of light manual activity. (15-30%)
- ☐ Class 3 — Moderate limitation of functional capacity; capable of clerical administrative (sedentary) activity. (35-55%)
- ☐ Class 4 — Marked limitation. (60-70%)
- ☐ Class 5 — Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)
- ☐ Remarks:

8. MENTAL/NERVOUS IMPAIRMENT (If applicable)

- ☐ Class 1 — Patient is able to function under stress and engage in interpersonal relations (no limitations)
- ☐ Class 2 — Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ☐ Class 3 — Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4 — Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5 — Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
- ☐ Remarks:

Do you believe patient is competent to endorse checks and direct the use of the proceeds thereof? ☒ Yes ☐ No

9. PROGNOSIS

	PATIENT'S JOB	ANY OTHER WORK
(a) Is patient now totally disabled?	☒ Yes ☐ No	☒ Yes ☐ No
(b) Do you expect a fundamental or marked change in the future?	☐ Yes ☒ No	☐ Yes ☒ No
(1) If "Yes," when will patient recover sufficiently to perform duties	___/___/___ Mo. Day Yr. ☐ 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mos. ☐ Never	___/___/___ Mo. Day Yr. ☐ 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mos. ☐ Never

(2) If "No," please explain:

10. REHABILITATION

	PATIENT'S JOB	ANY OTHER WORK
(a) Is patient a suitable candidate for trial employment?	☐ Yes ☐ No	☐ Yes ☐ No
(1) If "Yes," when could trial employment commence?	___/___/___ Mo. Day Yr. ☐ 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mos. ☐ Never	___/___/___ Mo. Day Yr. ☐ 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mos. ☐ Never

(2) If "Yes," what training will patient require?
(3) If "Yes," what type of employment would you suggest?
(4) If "No," please explain:

11. REMARKS

12/7/09

Physician's Signature

IRVING D. STROUSE, M.D., P.A.

Name (Attending Physician) Print

Degree [redacted] Telephone

279 3rd Ave 304 Long Branch NJ 07740

Street Address City or Town State or Province Zip Code

Claimant Full Name: Ralph R Van Deventer Jr.

WWID#: 10906

Please Fax to 518-880-6610 or Mail to the Address Listed Below

RALPH VANDEVENTER

DOB [redacted]

12-1-09

HISTORY: Patient is still having chronic back pain. He sees a pain management specialist and is continuing his physical therapy. He still has intermittent back pain. There is no significant sciatica, weakness or numbness present. There is no change in his neurologic status.

PLAN: Continue physical therapy for another 4 weeks.

RETURN: 6 weeks

IDS:pb

Heartland REHABILITATION SERVICES

222 OAK AVENUE SUITE 5
TOMS RIVER, NJ 08755
(732) 244-1595 Fax: (732) 505-3476

RE-EVALUATION REPORT

September 30, 2009

Irving Strouse, M.D.
279 Third Ave. Suite 504
Long Branch, NJ 07740
Fax: (732) 571-1937

Re: VanDeventer, Ralph
Dx: DISC DIS NEC/NOS-CERV
DISC DIS NEC/NOS-LUMBAR

DOB: [redacted]
DOI: [redacted]

Recently you referred your patient, Ralph VanDeventer, a [redacted]-year-old male, to our facility for treatment. Below, please find the results of the re-evaluation. This patient has attended 12 out of 18 visits. The patient has cancelled or no showed 6 times.

Subjective History

The patient states that his symptoms are getting worse. The current pain rating is 5.

Patient reports that he has been unable to work since 7/21/09 secondary to increased pain through the lumbar and cervical spine. Patient reports increased pain through the cervical and lumbar spine with sleeping, driving, sitting, etc.

Objective Findings

	Region	Side	Initial	Current	Goal	Centralized
AROM Cervical Extension	Cervical		50%	50%	70%	
AROM Cervical Flexion	Cervical		70%	70%	90%	
AROM Cervical Rotation - right	Cervical		40%	40%	60%	
AROM Cervical Sidebend - right	Cervical		20%	30%	50%	
AROM Lumbar Extension	Lumbo-Sacral		40%	40%	60%	
AROM Lumbar Flexion	Lumbo-Sacral		30%	30%	50%	
AROM Lumbar Sidebending - right	Lumbo-Sacral		40%	40%	60%	
AROM cervical rotation - left	Cervical		30%	50%	60%	
AROM cervical sidebend - left	Cervical		30%	30%	50%	
AROM lumbar sidebend - left	Lumbo-Sacral		50%	50%	70%	
MMT UE - WNL	Cervical		Yes	Yes		
Point Tenderness	Cervical	R	Severe	Severe	Minimal	
Postural Deviation	Cervical		Yes	Yes	No	

Tenderness to palpation at the bilateral upper trap and mid-scap region and bilateral lower lumbar paraspinal

Treatment

Exercise / Modality	Sets	Reps	Wts	Color	Qty	Comments
Corner Stretch	1	10			4	
Moist Heat					15	cervical and thoracic spine supine
Scapular Retraction	2	10			4	
Isotonic Shoulder Abduction	2	10	3		4	
Isotonic Shoulder Flexion	2	10	3		4	
Physioball Wall Squats	2	10			4	
Biceps Curl	2	10	4		4	
Hamstring Stretch Actively	1	15			4	
Lower trunk rotation	1	15			4	
Piriformis Stretch	1	15			4	
Single Knee To Chest	1	15			4	
Theraband Extension	2	10		R	4	
Theraband Scapula Retraction	2	10		R	4	

Assessment

The patient's rehabilitation potential is excellent. Patient presented with decreased pain following completion of today's treatment session. Slightly increased AROM. Patient continues to present with increased pain through the cervical and lumbar spine with sleeping, driving, sitting, lifting, etc. Patient would benefit from additional PT treatment to promote improved AROM and strength. Patient's treatment today consisted of MH and therapeutic exercise. Performed a re-evaluation of patient's status today. Reviewed comprehensive HEP, which consisted of cervical AROM (flex/ext/rotation), theraband scapular retraction, theraband extension, trunk rotations, SKTc, hamstring stretch and gastroc stretch.

Short Term Goals	*Body Part*	*Status*	*Time Frame*
Improve affected lumbar ROM as per objective findings	Cervical	Pending	2 Weeks
Independent with HEP	Cervical	Pending	2 Weeks
Demonstrate improved postural awareness	Cervical	Pending	2 Weeks
Decrease soft tissue dysfunction	Cervical	Pending	2 Weeks
Improve cervical ROM	Cervical	Pending	2 Weeks

Long Term Goals	*Body Part*	*Status*	*Time Frame*
Normalize L-S ROM	Cervical	Pending	3 Weeks
Return to work without pain	Cervical	Pending	3 Weeks
Cervical motion WFL to perform functional activities	Cervical	Pending	3 Weeks

Plan

We will see the patient 1 times a week for 3 weeks. The treatment plan may consist of the following:

Hot Pack / Cold Pack Therapeutic Exercise

The plan is to continue treatment as prescribed.

If you have any questions or concerns regarding the treatment program for Ralph please feel free to contact us. We will keep you informed of his progress. Thank you for this referral.

Regards,

Electronically Signed By
Jamie Vallone, PT
Lic: 40QA01055500

Heartland
REHABILITATION SERVICES

222 OAK AVENUE SUITE 5
TOMS RIVER, NJ 08755
(732) 244-1996 Fax: (732) 505-3476

DAILY NOTE

October 14, 2009

Patient: VanDeventer, Ralph DOB: [redacted]

Dx: DISC DIS NEC/NOS-CERV
DISC DIS NEC/NOS-LUMBAR

DOI: 05-01-09

Subjective

The current pain rating is 5.

Patient continues to report increased pain through the cervical and lumbar spine with sleeping, driving, sitting, etc. Patient reports that over the past weekend he experienced increased LBP pain he tried vacuum his daughter's room. He states that the pain incapacitated him for 2 days.

Objective Findings

	Region	Side	Initial	Current	Goal	Contralateral Limit
AROM Cervical Extension	Cervical		50%	50%	70%	
AROM Cervical Flexion	Cervical		70%	70%	90%	
AROM Cervical Rotation - right	Cervical		40%	40%	60%	
AROM Lumbar Extension	Lumbo-Sacral		40%	40%	60%	
AROM Lumbar Flexion	Lumbo-Sacral		30%	30%	50%	
AROM cervical rotation - left	Cervical		30%	50%	60%	

Tenderness to palpation at the bilateral upper trap and mid-scap region and bilateral lower lumbar paraspinal region. Patient is right hand dominant.

Exercises and Modalities

	Sets	Reps	Weights	Duration	Comments
Corner Stretch	1	10		3	
Moist Heat				15	cervical and thoracic spine supine
Scapular Retraction	2	10		4	
Isotonic Shoulder Abduction	2	10	3	4	
Isotonic Shoulder Flexion	2	10	3	4	
Physioball Wall Squats	2	10		4	
Biceps Curl	2	10	4	4	
Hamstring Stretch Actively	1	15		3	
Lower trunk rotation	1	15		3	
Piriformis Stretch	1	15		4	
Single Knee To Chest	1	15		4	
Theraband Extension	2	10		4	

Theraband Scapula Retraction	2	10		4	

Assessment

Patient is able to perform exercises with no change in pain. Tolerance to treatment is good. Patient presented with decreased pain following completion of today's treatment session. Slightly increased AROM. Patient continues to present with increased pain through the cervical and lumbar spine with sleeping, driving, sitting, lifting, etc. Patient's treatment today consisted of MH and therapeutic exercise. Reviewed comprehensive HEP, which consisted of cervical AROM (flex/ext/rotation), theraband scapular retraction, theraband extension, trunk rotations, SKTC, hamstring stretch and gastroc stretch

Plan

Continue current treatment plan.

Electronically Signed By
Sandra Smith, PTA 40QB000348
Lic:

Electronically Cosigned By
Jamie Vallone, PT
Lic: 40QA01055500

Pollack Health and Wellness, Inc.

A holistic multi-disciplined approach to wellness

137 Atlantic City Blvd.• Beachwood, NJ 08722-2935
Chiropractic 732-244-0222 • Physical Therapy 732-244-8666 • Fax: 732-244-0450
pchiropractic@comcast.net

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Cold Laser therapy
Electric & galvanic muscle stimulation
Thermal modalities
Soft-stissue mobilization
Ultra-sound
Manual traction

MYOFACIAL RELEASE

MASSAGE THERAPY

LIFESTYLE MODIFICATION with NLP
(neuro-linguistic programming)

STOP SMOKING PROGRAM
with electro-acupuncture

NUTRITIONAL PURIFICATION PROGRAM

Date: 11-2-09

Patient Name: Ralph Vandeventer

This is your professional home program. Do only the repetitions and exercises assigned. If you experience shortness of breath or muscle soreness – discontinue.

Call with any questions.

Jane Delaney P.T.

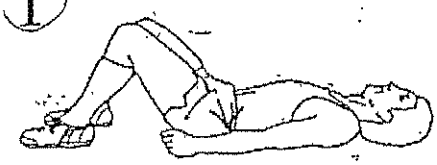
Jane Delaney, P.T.
QA04970

LOW BACK PRESCRIPTION PAD

GENERAL DIRECTIONS

- The following exercises are a collection of exercises most commonly used with people with back problems.
- Your doctor and/or therapist will choose the exercises you are to perform.
- THESE EXERCISES SHOULD BE DONE ONLY WITH THE APPROVAL AND SUPERVISION OF YOUR DOCTOR AND THERAPIST.

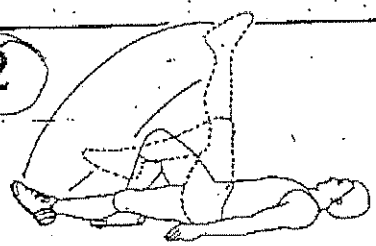
1



Tilt hips toward head, pressing low back firmly to floor and tightening abdominals. Hold 2-3 seconds.

# of times 10X Hold ____ sec.

2



Pull leg to bent position then follow motion shown. Complete all repetitions to one side.

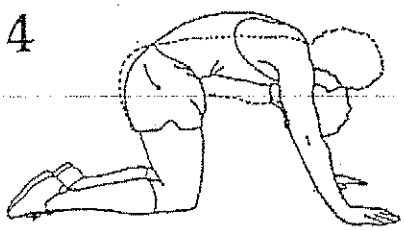
# of times 10X Hold ____ sec.

3

Tighten buttocks while pressing pelvis to floor.

# of times ____ Hold ____ sec.

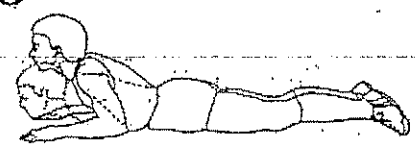
4



Arch entire back. Bring pelvis forward and chin to chest while tightening abdominals.

# of times ____ Hold ____ sec.

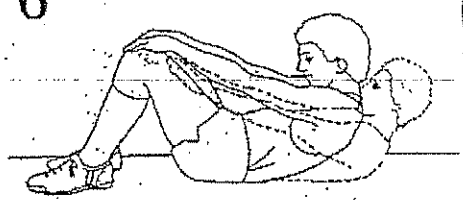
5



Press upper body upward to position shown, keeping pelvis on floor.

# of times ____ Hold ____ sec.

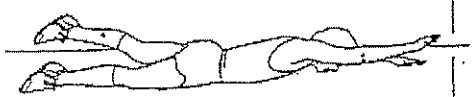
6



Keeping low back flat on floor, curl upper body toward pelvis until hands cup kneecaps.

# of times ____ Hold ____ sec.

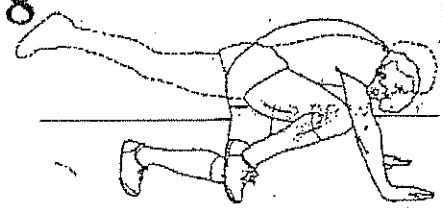
7



Raise one hand and opposite leg six inches off floor for three seconds. Alternate sides.

# of times ____ Hold ____ sec.

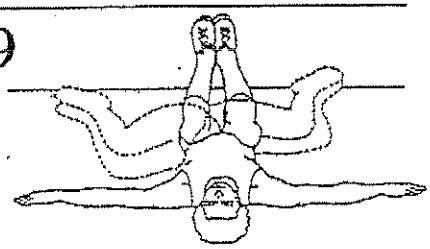
8



Tuck leg to chest, then drive leg back and up until it is straight and level with body.

# of times ____ Hold ____ sec.

9



Keeping shoulders flat on floor, slowly rotate hips and legs from side to side.

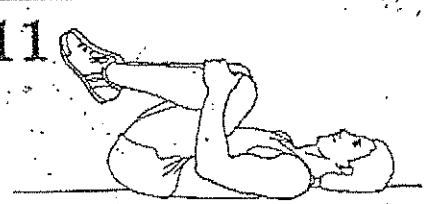
# of times ____ Hold ____ sec.

10

Keeping low back flat, bring each knee to chest for 30 seconds. Alternate legs.

# of times ____ Hold ____ sec.

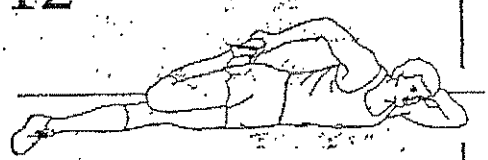
11



Keeping low back flat, bring knees to chest for one minute.

# of times ____ Hold ____ sec.

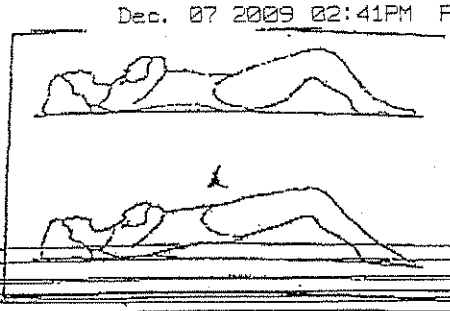
12



Pull heel to buttocks while contracting abdominals. Stretches thigh.

# of times ____ Hold ____ sec.

Starting Position: Lie on your back on a table or flat surface. Your feet are flat on the surface and your knees are bent. Keep your legs together Cross your arms over your chest.
Action: Tilt your pelvis and push your low back to the floor as in the previous exercise, then slowly lift your buttocks off the floor as far as possible without straining. Maintain this position for 5 seconds. Lower your buttocks to the floor Do not hold breath.



Do Not Cause Pain.

10x

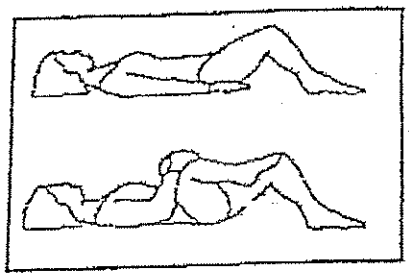
Exercise 5: Lower Abdominal Exercises

Starting Position: Lie on your back on a table or firm surface. Knees bent and feet flat on the table. Flatten your back to the floor by pulling your abdominal muscles up and in.
Action:

A. Bring one knee toward your chest. Hold this position for _____ seconds. Lower your leg to the starting position. Then repeat on your opposite knee.
B. Bring one knee toward your chest. Straighten the knee Hold for _____ seconds Slowly lower the leg to the starting position. Repeat on opposite leg.
C. Raise your leg keeping your knee straight. Hold for _____ seconds. Slowly lower the leg to the floor. Repeat on the opposite leg.

Maintain your pelvic tilt and keep your resting leg relaxed at all times. Do not hold your breath.

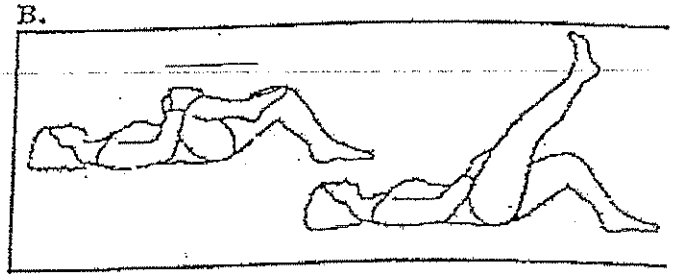
Do Not Cause Pain.

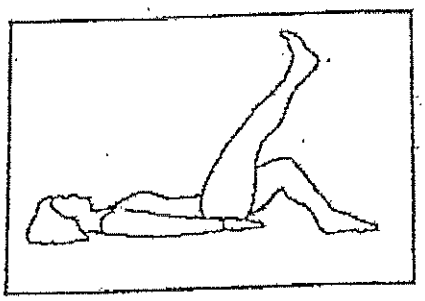


A.

10x

B.

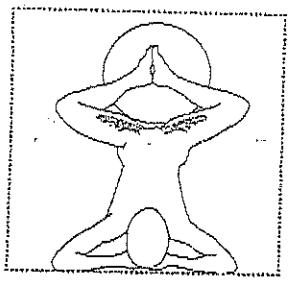




C.

Exercise 6: Curl Ups

A.



anatomy on the ball: the groin muscles

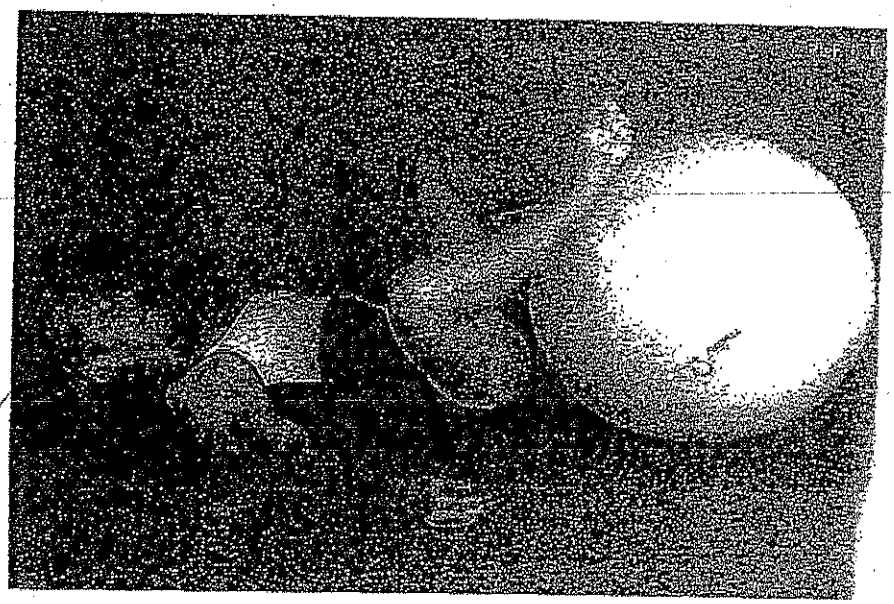
Adduction of the hip—movement of the hip toward the body in the frontal plane—is the primary function of the groin muscles. These muscles, located in the inner thighs, help to stabilize the femur and connect it to the pelvis. The groin muscles are frequently torn if not warmed up or stretched properly.

Frog Stretch

The following exercise is a comfortable, relaxing stretch that is best performed in bare feet so that the feet will not slip on the ball. The mat supports the back and there is no stress on the ligaments in the lower back or the pelvis. You are trying to stretch the inner thighs, or adductors. If these muscles are not regularly stretched they pull on the pelvis and lower back. For some people even the feet and ankle muscles will feel a stretch while in the Frog.

Purpose To stretch the inner thighs.

Watchpoints • You should feel tension in the center of the groin muscle, not high up in the groin (in the tendon). • Hold the stretch as long as it is comfortable.

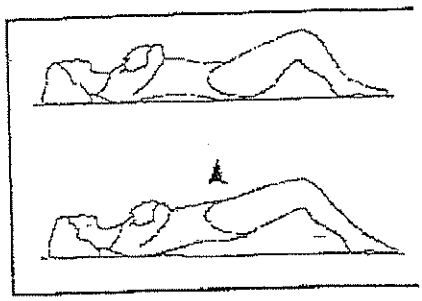


starting position

Lie on your back with the soles of the feet together and resting on the ball. Let the knees gently open to the side in a frog-leg shape (fig. 8.1).

movement

1. Rest the hands on the inner thighs but do not force down the knees.
2. Relax. Allow gravity to ease open the inner thighs.
3. Over time you can gently ease the feet, a fraction of an inch at a time, closer to the groin area.
4. Stay in this stretch for as long as you like.



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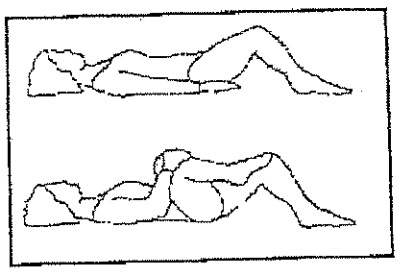
Do Not Cause Pain.

Exercise 5: Lower Abdominal Exercises



Starting Position: Lie on your back on a table or firm surface. Knees bent and feet flat on the table. Flatten your back to the floor by pulling your abdominal muscles up and in.
Action:

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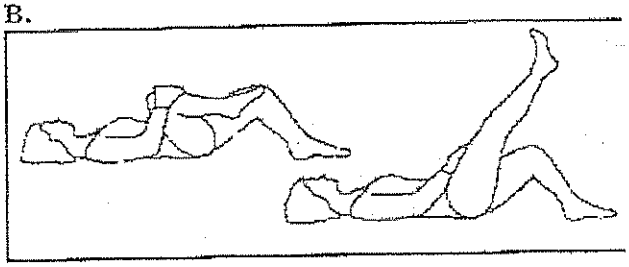
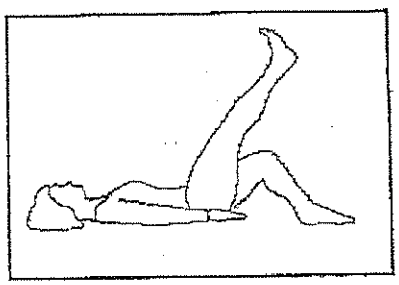
Maintain your pelvic tilt and keep your resting leg relaxed at all times. Do not hold your breath.

Do Not Cause Pain.

B.

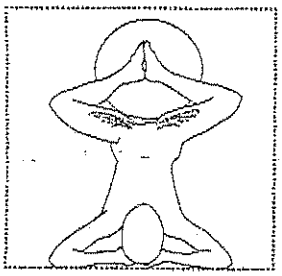


C.



Exercise 6: Curl Ups

A.



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Purpose To stretch the inner thighs.

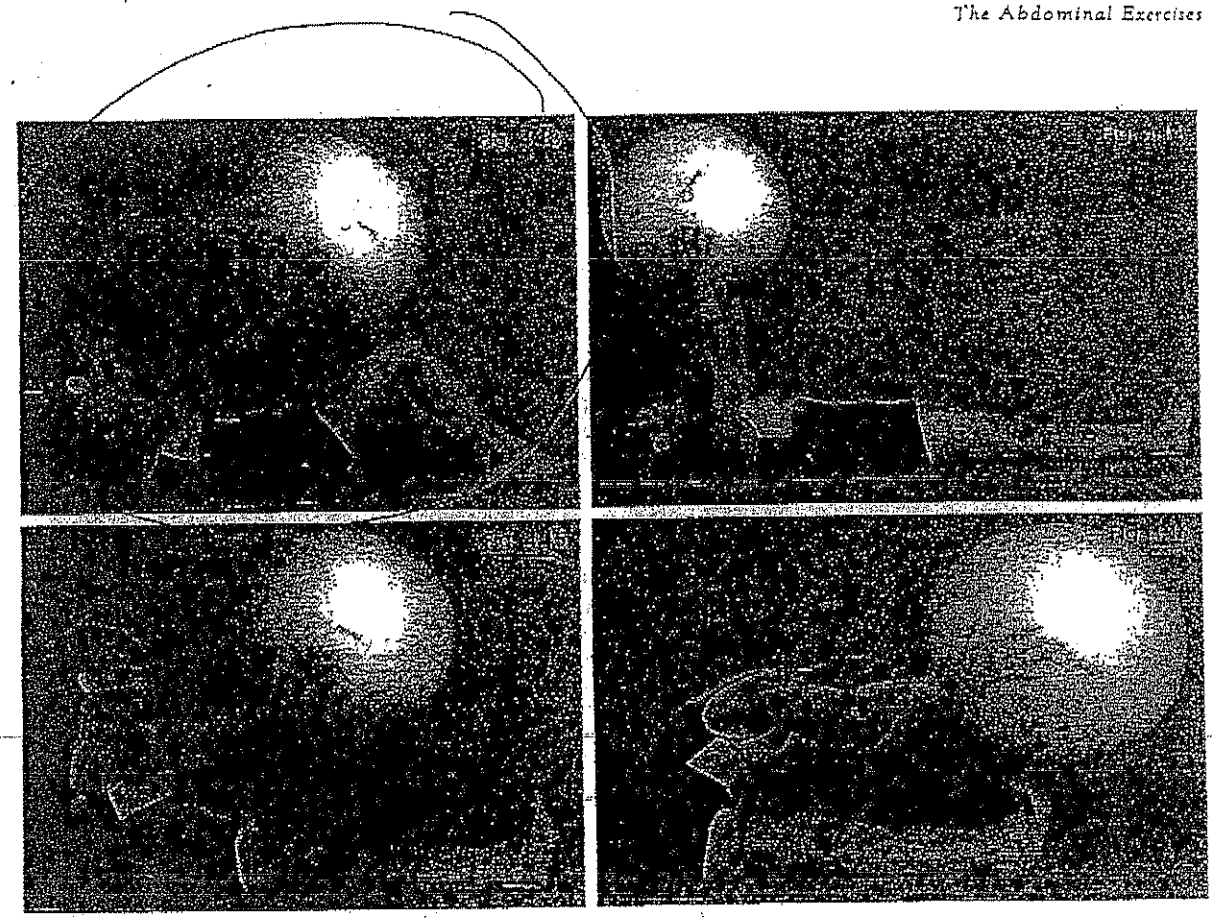
Watchpoints • You should feel tension in the center of the groin muscle, not high up in the groin (in the tendon). • Hold the stretch as long as it is comfortable.

starting position

Lie on your back with the soles of the feet together and resting on the ball. Let the knees gently open to the side in a frog-leg shape (fig. 8.1).

movement

1. Rest the hands on the inner thighs but do not force down the knees.
2. Relax. Allow gravity to ease open the inner thighs.
3. Over time you can gently ease the feet, a fraction of an inch at a time, closer to the groin area.
4. Stay in this stretch for as long as you like.

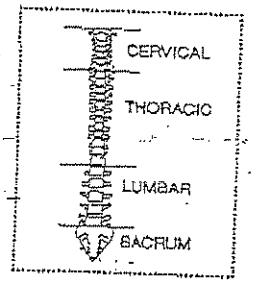


movement 1: half rollup

1. Inhale to lift the ball to the ceiling, head still on the mat.
2. Exhale to flex the body up, chin to chest, bringing the ball just above the knees (fig. 4.13).
3. Inhale to start to lift the ball back.
4. Exhale to roll back down one bone at a time.
5. Repeat six to eight times.

movement 2: full rollup

1. Inhale to lift the ball to the ceiling (fig. 4.14).
2. Exhale to flex the body up, peeling away from the mat one vertebra at a time (fig. 4.15).
3. Inhale to extend the ball toward your toes, and start to roll back pulling your navel toward your spine (fig. 4.16).
4. Exhale to reverse the movement, rolling down one vertebra at a time.
5. When your shoulder blades reach the mat, the ball floats back overhead.
6. Repeat six to eight times.



anatomy on the ball: the spine

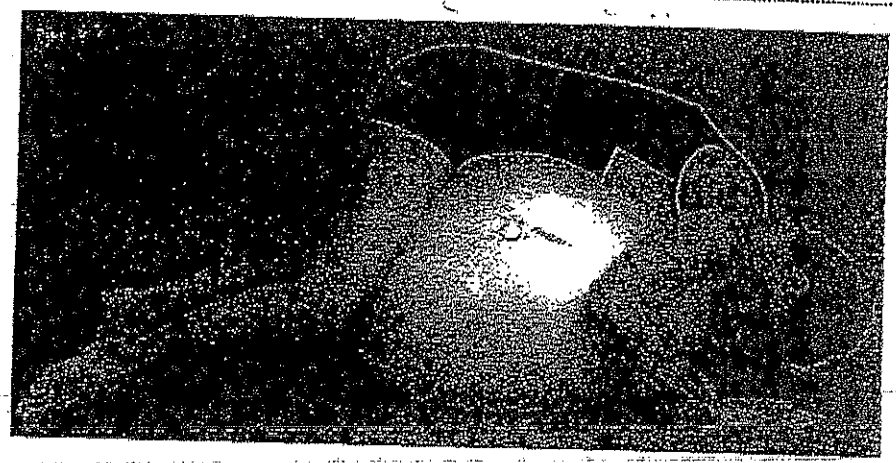
As you allow your spine to take the shape of the ball, imagine in your mind's eye your backbone. Your spine consists of twenty-four spool-shaped vertebrae plus the sacrum—the triangular bone at the base of the spine. Below the sacrum is your tailbone.

As gravity gently opens you up and you feel a pleasant release in the neck and upper spine, can you image the sections of the spine? In the cervical section there are seven neck bones, or vertebrae; in the thoracic, or upper back, there are twelve; and in the lumbar, or lower back, there are five.

Because of the number of bones that make up the spine, and the joints between them, the spine is very mobile. Go deeper into your stretch, so that your head is one inch from the ground. Send the breath into your back. Allow gravity to do its work. Enjoy!

Purpose To relax body and mind. To allow gravity to naturally stretch the neck and spine.

Watchpoints • Take care that long hair does not get stuck under the ball as you roll forward. • The chest and breasts should not feel compressed. Letting a small amount of air out of the ball makes this pose more comfortable for some.



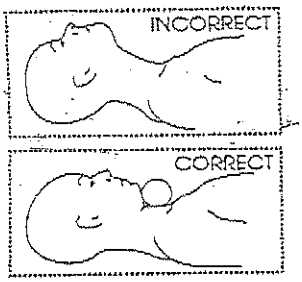
starting position

Kneel behind the ball and carefully lay your body over it, face down.

movement

1. Keeping the movement small to begin, roll over the ball, face down.
2. Place your hands a few inches apart on the ground in front of the ball, toes on the ground behind you.
3. Go deeper into the stretch so that your head is only one inch from the ground (fig. 2.7).
4. Feel your spine release.
5. Practice breathing into the back of the rib cage. Then try breathing deep into the abdominals, noticing how the pelvic muscles release with that breath.

Rib cage breathing takes time to master but the results are well worth the effort. Return to this chapter from time to time and review the breathing exercises. It is important to remember that the breathing patterns in the following chapters are not written in stone. Many teachers and students take liberties with breathing patterns and so can you. The most important thing is not to hold your breath. Be sure that you build breathers or relaxation positions into your workout. In the next chapter we will begin to add body movements to the breath patterns. The postural exercises are designed to foster an awareness of your spine. Sitting, bouncing, and performing the postural exercises will strengthen the deep small spinal muscles and bring the body back into balance.



head position on the mat

When lying on your back be sure your head is not tilted so far that your neck arches. You may need to drop the chin gently forward as if you have a tennis ball held at the throat. This correction will produce a sensation of lengthening through the neck, which is what we want when the head is on the mat. This is what I mean by the directive "lengthen through the back of the neck." In some cases a flat pillow may be necessary.

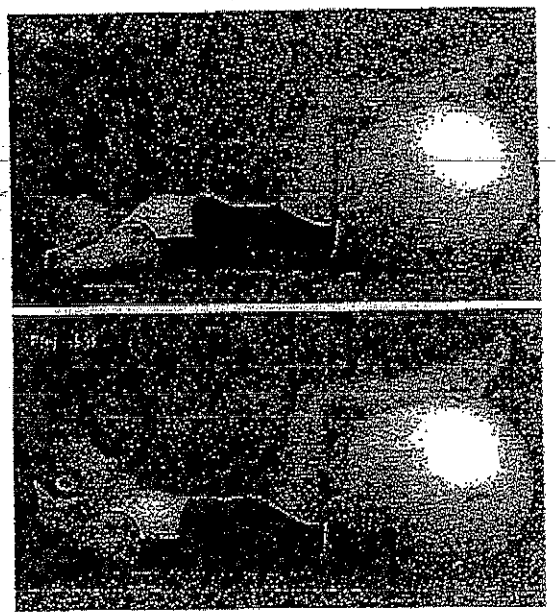
To lift the head safely, first nod or drop the chin forward and curve your head up immediately as you empty the air from the lungs. Avoid sticking your chin into the air or grinding it into the chest, for that puts a lot of pressure on the back of the neck. Make sure your gaze is on your thighs and not on the ceiling when the head is up.

Little Abdominal Curls

This is the first in a series of highly effective abdominal exercises. This exercise will teach you how to curl the upper body while keeping the navel-to-spine connection. This small exercise is so much more efficient than hooking your feet under a couch and heaving yourself through a series of sit-ups, which creates strong hip flexors, not abdominals. Hands placed behind the head will help you to practice safely lifting the head from the mat. Try to keep your pelvis in neutral and not tuck up the tailbone. If you have never done Pilates before, you may find the moves to be much slower than you are used to.

Purpose To strengthen the abdominal muscles. To learn to lift the head off the mat. To help ease mild lower back pain.

Watchpoints • Try to use the abdominals, not the hands, to lift the head. • Try not to let the chin dig into the chest. • Keep the pelvis in neutral.



starting position

1. Lie on your back with the ball under your knees, knees in line with your hips.
2. Check that the back of the neck is in "lengthened position." Place hands behind the head, elbows wide (fig. 4.3).

movement

1. Inhale to prepare and begin to drop the chin while the head is still on the mat.
2. Exhale to lift the head, flexing the upper body.
3. Inhale and stay; your gaze is at your thighs, not at the ceiling (fig 4.4).
4. Exhale to return your head to the mat.
5. Repeat eight times, slow and controlled.

Hamstring Stretch

There are three muscles that run down the back of the thigh that make up the hamstrings. These muscles extend from the sitz bones to the inside and outside of the knee. The hamstring muscles do not stretch behind the knee; thus you should not feel this stretch in the back of the knee. If you feel pressure on the back of the knee, keep the knee slightly bent. Tight hamstrings cause poor posture and lower back pain and problems.

Purpose To stretch the hamstrings.

Watchpoints • In all three movements the tailbone should remain on the mat. • In movements 1 and 2 be aware of the neck as you stretch. Try not to arch the back and shorten the neck. Drop the chin gently as if you have a tennis ball at the throat, or place a flat pillow under the head. • In movement 3 be aware that attempting to grab the toes or dorsiflex the foot makes the stretch more intense because it involves the calf muscle as well.

starting position

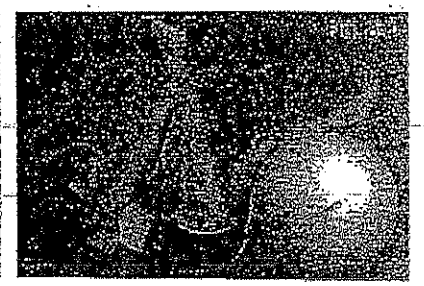
Lie on your back with the back of both calves resting on the ball.

movement 1: with towel or scarf

1. Sling a towel across the arch of the left foot. Keeping the tailbone anchored on the mat, slowly straighten the left leg into the air (fig. 8.2).
2. Hold for 30 to 60 seconds. Breathe naturally.
3. Return the leg to the ball and switch sides.

movement 2: without towel

1. Lift one leg off the ball keeping the leg as straight as possible. The back of the knee can be soft. Try to keep the tailbone on the mat (fig. 8.3).
2. Hold for 5 to 20 seconds. Breathe naturally.
3. Lower the leg to the ball and switch sides.



movement 3—intermediate

1. Place both hands at the back of the thigh.
2. Inhale to prepare.
3. Exhale to slowly walk your hands up the back of the leg (fig. 8.4).
4. Inhale at the top, reaching the hand toward the toes without letting the shoulders come up.
5. Exhale to walk down the back of the leg.
6. Repeat three times on each leg.

Hip Stretch

You can move directly from the Hamstring Stretch into the Hip Stretch. The hip rotators are six small muscles that cross the back of the pelvis and are responsible for turning the thigh outward. The gluteus maximus is the main buttocks muscle. The ball is a great aid to this traditional stretch because you don't need to use the hands to pull the leg closer to the body.

Purpose To stretch the large gluteus maximus and the external hip rotators.

Watchpoints • Keep the upper body and head on the mat. • Rest the sides of the pelvis evenly on the mat.

starting position

Lie on your back with the backs of both legs resting on the ball.

movement

1. Allow the left foot to roll the ball straight out away from the body.
2. Cross the right foot over the left thigh. There should be no tension in the hip muscles.
3. Press the left heel on the ball, bend the left knee, and slowly pull the ball toward the body, keeping the right knee open (fig. 8.5). Stop when you feel a tension in the deep hip muscles and the back of the right buttock.
4. Roll the ball back out to release the tension and then slowly ease it back.
5. Do three stretches on each side. Hold for 30 to 60 seconds each.

movement 4: lower and lift

1. Feet are sitz-bone distance apart and parallel. Lift the heels up high, as if you were wearing high-heeled shoes (fig. 6.25).
2. Inhale to lower, keeping the heels up (fig. 6.26).
3. Exhale to push the heels down, keeping the knees bent (fig. 6.27).
4. Inhale to lift the heels, keeping the knees bent.
5. Exhale to straighten the legs, keeping the heels up.
6. Inhale to bend the knees, keeping the heels up.
7. Exhale to push the heels down once, keeping the knees bent.
8. Inhale to lift the heels, keeping the body in the same plane and knees bent.
9. Exhale to lower the heels twice, keeping the knees bent.
10. Inhale to lift the heels, keeping the knees bent.
11. Exhale to straighten the legs.
12. Repeat, building up to five repetitions of this movement sequence.

movement 5: wide squat

1. Begin with feet wider than shoulder-distance apart and slightly turned out (fig. 6.28).
2. Inhale to bend the knees, keeping the heels down. The knees should be aligned over the toes (fig. 6.29).
3. Exhale to stretch the legs.
4. Repeat six to eight times.

ACTIVITIES OF DAILY LIVING INSTRUCTION

In-Office Instruction

GENERAL INSTRUCTIONS

Do only those exercises taught to you by your therapist. Exercises are best done on a firm surface such as the floor or a very firm bed.

WHEN STANDING

1. Keep your head level and your chin slightly tucked in.
2. Stand tall, stretching the top of your head toward the ceiling.
3. Relax your shoulders.
4. Tighten your stomach muscles to tuck in your stomach. This will help prevent excessive swayback, or lordosis, in the lower part of your back.

WHEN SITTING

1. Keep your head level and chin up.
2. Keep your buttocks to the back of the chair and maintain a slight inward curve in your lower back. Sometimes a small pillow or rolled towel in the small of your back helps. Do not slouch.
3. Keep your feet comfortably apart and supported so that your knees are level with your hips.

WHEN LYING

1. Use a firm mattress.
2. Lie on your side with your hips and knees slightly bent and with a pillow between your legs.
3. If you find you are able to sleep only on your back, a pillow under your knees may take the strain off your lower back.

WHEN LIFTING

1. Keep your head level and chin up.
2. Keep your back straight, bend your knees and squat as low as possible, keeping your feet apart.
3. Lift with the strength of your legs.
4. Never twist or turn while lifting.
5. Once you've picked up the object, hold it close to you.

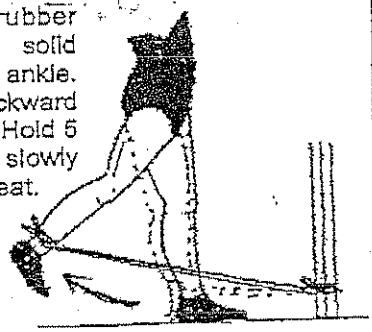
HIP

Elastic Tubing Resistive Kinetic Activities

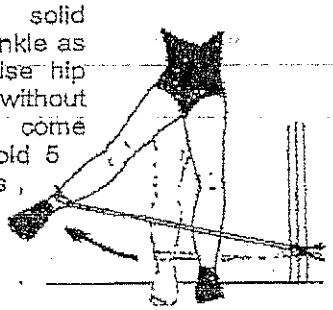
Name _____ Date _____

Flexion: Anchor rubber tubing to solid object and around ankle. Pull leg forward as shown. Hold 5 seconds, slowly relax. Repeat.

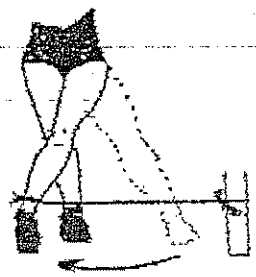
Extension: Anchor rubber tubing to solid object and ankle. Lift leg backward as shown. Hold 5 seconds, slowly relax. Repeat.



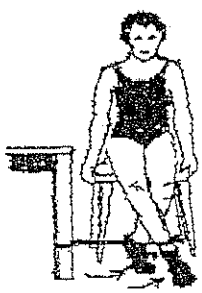
Abduction: Anchor rubber tubing to solid object and ankle as shown. Raise hip out to side, without letting it come forward. Hold 5 seconds, slowly relax. Repeat.



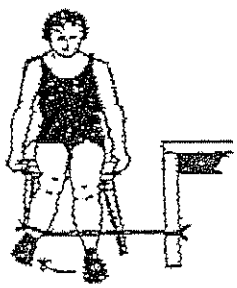
Adduction: Anchor rubber tubing to solid object and ankle as shown. Stand with toe pointed out to side. Now cross the leg in front of your other leg. Hold 5 seconds, slowly relax. Repeat.



External Rotation: Anchor rubber tubing to solid object and ankle. Sit in chair as shown. Rotate ankle inward and slightly upward. Hold 5 seconds, slowly relax. Repeat.



Internal Rotation: Anchor rubber tubing to solid object and ankle. Sit in chair as shown. Rotate ankle outward, keeping knees together. Hold 5 seconds, slowly relax. Repeat.



EXERCISE GUIDELINES:
Periodically check the tubing for stress and the knot for slipping. **Stop immediately if you experience pain, nausea or dizziness.**

POLLACK HEAL[illegible]and WELLNESS, Inc.
137 Atlantic City Blvd./Rt. 166
Beachwood, NJ 08722-2935
732-244-0222

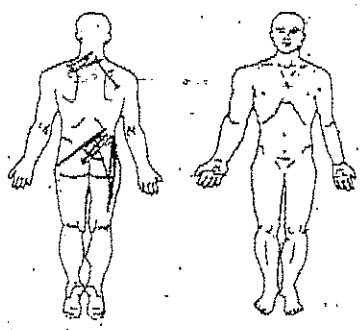
Date 10/2/09

Name Ralph Van Deventer

Please rate your level of pain on a scale of 1 to 10 (1 = low, 10 = high):

Neck	10	Headache	
Middle back		Low back	10
L arm/wrist		R arm/wrist	
L shoulder	10	R shoulder	
L leg/hip	10	R knee/ankle	
L Other		R Other	

Please circle area of pain:



Area below for office use only

TREATMENT

Manipulation

C1 C2 C3 C4 C5 C6 C7

T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

L1 L2 L3 L4 L5

Sacroiliac Joints _____
Sacrum _____
Pelvis _____

X Exam
_____ Re-exam
_____ Follow up
_____ Final Exam
_____ CMT-Diversified C T L S P
_____ CMT-Activator C T L S P
_____ Manual Low Force
_____ Manual Traction
_____ Therapies as ordered (See therapy/treatment notes)

FINDINGS

Cervical (Tenderness/Spasm) Thoracic (Tenderness/Spasm) Lumbar (Tenderness/Spasm)

L R Shoulder Other _____

GOALS (Pain Relief) (Increase ROM) (Increase Strength) (Decrease Edema)

ASSESSMENT

Diagnosis _____ Unchanged _____ Improvements _____ Aggravation C T L S _____ New Diagnosis _____
Progress X As expected _____ Slower than expected X Complicated by _____
Prognosis: _____ Excellent - continued improvement expected, permanent residuals not expected
X Good - continued improvement anticipated, permanent residuals possible
_____ Favorable - continued improvement possible, permanent residuals probable
_____ Poor - continued improvement doubtful, permanenet rasiduals expected

PLAN

_____ Continue with treatment as outlined. Treatment is medically necessary.
X Acute phase: Stabilize condition, control inflammation, reduce spasm and pain. (TX-daily for ____ days.)
_____ Sub-acute phase: Support soft tissue repair, mobilize spinal joints to improve ROM (TX - 3X/week for 4 weeks.)
_____ Rehabilitation phase: Continued passive care with addition of active care to increase ROM, endurance, and strength for return to normal daily activities. (TX-1-2X/week for ____ weeks until MMI.)
_____ Exacerbation: Aggravation of condition, stabilize condition to prior state; ____ PL not at MMI ____ Pt. at MMI

I attest that the above information is accurate to the best of my knowledge and that the above servic es were rendered on my behalf. I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing that I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Physician's signature

Patient signature

Area below for office use only

NOTES:

FROM : A-Z VIDEO FAX NO. : 7322704287 Dec. 07 2009 02:51PM P26

CHIROPRACTIC NOTES

Client: Ralph Vandeventer Number: ______ Page: ______

◆ Date of Service: 10/2/09
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan ______
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged 10 60
Note: EXAM, [illegible] Review MRI - Herniated Cerv/Lumbar Discs [illegible] Signed [signature]

◆ Date of Service: 10/27/09
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan ______ 9
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged
Note: [illegible] Lumbar decompression [illegible] Signed [signature]

◆ Date of Service: 10/28/09
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan ______
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports) 8 8
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged
Note: [illegible] cold laser [illegible] therapeutic exercise [illegible] lumbar decomp Signed [signature]

◆ Date of Service: 10/29/09
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan ______
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged
Note: [illegible] therapeutic Lumbar decompression, ICE, Stim, laser, assisted stretch/exercise [illegible] Signed [signature]

◆ Date of Service: 10-30-09
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan ______
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged
Note: [illegible] therapeutic exercise [illegible] lumbar decompress Signed [signature]

◆ Date of Service: 11/2/09
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan ______
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged
Note: [illegible] cold laser, therapeutic exercise, lumbar decomp [illegible] Signed [signature]

received on 12/7/2009 12:40:29 PM [Eastern Standard Time]

CHIROPRACTIC NOTES

Patient: Ralph van Deventer Number: _____ Page: _____

✦ Date of Service: 11-3-09
Subjective: Patient states there is: ☐ Pain ☑ Spasm ☑ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptom
Objective: Patient demonstrates: ☐ Pain ☑ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviatio
Plan/Treatment: ☑ Chiropractic Adjustment ☑ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☑ Fair ☐ Poor ☐ Guarded ☐ Discharged Pain scale 1 – 10 6 ADL scale 1 – 10 5
Note: [illegible]
Signed [signature]

✦ Date of Service: 11-5-09
Subjective: Patient states there is: ☐ Pain ☑ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptom
Objective: Patient demonstrates: ☐ Pain ☑ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviatio
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged Pain scale 1 – 10 6 ADL scale 1 – 10 5
Note: [illegible]
Signed [signature]

✦ Date of Service: 11 9 09
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptom
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviatio
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged Pain scale 1 – 10 5 ADL scale 1 – 10 4
Note: [illegible]
Signed [signature]

✦ Date of Service: 11-10 09
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptom
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviatio
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged Pain scale 1 – 10 4 ADL scale 1 – 10 4
Note: [illegible]
Signed [signature]

✦ Date of Service: 11-12 09
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptom
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviati
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged Pain scale 1 – 10 5 ADL scale 1 – 10 5
Note: [illegible]
Signed [signature]

✦ Date of Service: 11-13-09
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptom
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviat
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged Pain scale 1 – 10 4 ADL scale 1 – 10 4
Note: [illegible]
Signed [signature]

FROM : A-Z VIDEO FAX NO. : 7322704287 Dec. 07 2009 02:52PM P28

CHIROPRACTIC NOTES

Patient: Ralph vanDeventer Number: ______ Page: ______

◆ Date of Service: 11-16-09
Subjective: Patient states there is: ☒ Pain ☒ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☒ Radicular Symptoms
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☒ Spasm ☐ ROM Restricted ☒ Decreased Strength ☒ Postural Deviation
Plan/Treatment: ☒ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☒ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged Pain scale 1 – 10 6 ADL scale 1 – 10 5
Note: [illegible handwriting]
Signed [signature]

◆ Date of Service: 11-17-09
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☐ Weakness ☒ ADL Difficulties ☒ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☒ Spasm ☒ ROM Restricted ☐ Decreased Strength ☒ Postural Deviation
Plan/Treatment: ☒ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☒ Fair ☐ Poor ☒ Guarded ☐ Discharged Pain scale 1 – 10 5-6 ADL scale 1 – 10 6
Note: [illegible handwriting]
Signed [signature]

◆ Date of Service: 11-24-09
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☐ Weakness ☒ ADL Difficulties ☒ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☒ Spasm ☒ ROM Restricted ☐ Decreased Strength ☒ Postural Deviation
Plan/Treatment: ☒ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☒ Fair ☐ Poor ☐ Guarded ☐ Discharged Pain scale 1 – 10 5 ADL scale 1 – 10 [illegible]
Note: [illegible handwriting]
Signed [signature]

◆ Date of Service: 12-1-09
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☒ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☒ Spasm ☒ ROM Restricted ☐ Decreased Strength ☒ Postural Deviation
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☒ Fair ☐ Poor ☐ Guarded ☐ Discharged Pain scale 1 – 10 4-5 ADL scale 1 – 10 [illegible]
Note: [illegible handwriting]
Signed [signature]

◆ Date of Service: ______
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged Pain scale 1 – 10 ______ ADL scale 1 – 10 ______
Note: ______
Signed ______

◆ Date of Service: ______
Subjective: Patient states there is: ☐ Pain ☐ Spasm ☐ ROM Restricted ☐ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☐ Pain ☐ Swelling ☐ Spasm ☐ ROM Restricted ☐ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☐ Chiropractic Adjustment ☐ Continue Treatment Plan ☐ Alter Treatment Plan
Assessment: ☐ Re-evaluation 99213 ☐ Manual Musc. Test 95833 ☐ Inclinometry 95851 (See attached reports)
Therapy Tolerated: ☐ Well ☐ Fair ☐ Poor ☐ Guarded ☐ Discharged Pain scale 1 – 10 ______ ADL scale 1 – 10 ______
Note: ______
Signed ______

received on 12/7/2009 12:40:29 PM [Eastern Standard Time]

4 - 25

PHYSICAL THERAPY NOTES

Patient: Ralph Vandeventer Number: ______ Page: ______

◆ Date of Service: 10/27/09 6/10

Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
Rehab: ☒ Therapeutic Exercises 97110 ☐ Therapeutic Activities 97530 ☐ NMR 97112 ☐ Gait Training 97116 ☐ Aqua. Ther. 97113
☐ ADL 97535 ☐ Work Hardening (init 2 hrs.) 97545 ☐ Work Hardening (add hr.) 97546
(See Rehab Flow Sheets)
Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: Mechanical tx x 45 ice-estim light therapy as per protocol manual technique therapeutic exercise. Pt tol tx well. Pt cont. cplan

Signed: J Delong PT

◆ Date of Service: 10/28/09 6/10

Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
Rehab: ☒ Therapeutic Exercises 97110 ☐ Therapeutic Activities 97530 ☐ NMR 97112 ☐ Gait Training 97116 ☐ Aqua. Ther. 97113
☐ ADL 97535 ☐ Work Hardening (init 2 hrs.) 97545 ☐ Work Hardening (add hr.) 97546
(See Rehab Flow Sheets)
Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☐ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: Mechanical tx x 45 ice-estim light therapy as per protocol manual technique therapeutic exercise. Pt tol tx well. Pt cont. cplan

Signed: J Delong PT

◆ Date of Service: 10/29/09 5/10 applied taping

Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☐ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☐ Man. Therapy 97140
Rehab: ☒ Therapeutic Exercises 97110 ☐ Therapeutic Activities 97530 ☐ NMR 97112 ☐ Gait Training 97116 ☐ Aqua. Ther. 97113
☐ ADL 97535 ☐ Work Hardening (init 2 hrs.) 97545 ☐ Work Hardening (add hr.) 97546
(See Rehab Flow Sheets)
Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: ice-estim, mechanical tx x 45 light therapy as per protocol therapeutic exercise. Pt tol tx well. Pt cont. cplan

Signed: J Delong PT

◆ Date of Service: 10/30/09 5/10

Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
Rehab: ☒ Therapeutic Exercises 97110 ☐ Therapeutic Activities 97530 ☐ NMR 97112 ☐ Gait Training 97116 ☐ Aqua. Ther. 97113
☐ ADL 97535 ☐ Work Hardening (init 2 hrs.) 97545 ☐ Work Hardening (add hr.) 97546
(See Rehab Flow Sheets)
Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: ice-estim mechanical tx x 45 light therapy as per protocol therapeutic exercise. Pt tol tx well. Pt cont. cplan

Signed: J Delong PT

◆ Date of Service: 11-2-09 5/10

Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
Rehab: ☒ Therapeutic Exercises 97110 ☐ Therapeutic Activities 97530 ☐ NMR 97112 ☐ Gait Training 97116 ☐ Aqua. Ther. 97113
☐ ADL 97535 ☐ Work Hardening (init 2 hrs.) 97545 ☐ Work Hardening (add hr.) 97546
(See Rehab Flow Sheets) light therapy as per protocol
Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: Mechanical tx x 45 ice-estim light therapy as per protocol therapeutic exercise. Pt tol tx well. Pt cont. cplan

Signed: J Delong PT

[illegible] issued HEP

FROM : A-Z VIDEO FAX NO. : 7322704287 Dec. 07 2009 02:54PM P30

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PHYSICAL THERAPY NOTES

Patient: Ralph Vanderenter Number: ______ Page: ______

◆ Date of Service: 11-3-09 4/10
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
Rehab: ☒ Therapeutic Exercises 97110 ☐ Therapeutic Activities 97530 ☐ NMR 97112 ☐ Gait Training 97116 ☐ Aqua. Ther. 97113
☐ ADL 97535 ☐ Work Hardening (init 2 hrs.) 97545 ☐ Work Hardening (add hr.) 97546
(See Rehab Flow Sheets)
Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: mechanical tx x45 ice-estim light therapy as per protocol manual technique therapeutic exercise
[illegible] to well pt cont care
Signed: [illegible] PT
taping applied

◆ Date of Service: 11-5-09 (4/10)
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
Rehab: ☒ Therapeutic Exercises 97110 ☐ Therapeutic Activities 97530 ☐ NMR 97112 ☐ Gait Training 97116 ☐ Aqua. Ther. 97113
☐ ADL 97535 ☐ Work Hardening (init 2 hrs.) 97545 ☐ Work Hardening (add hr.) 97546
(See Rehab Flow Sheets)
Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: mechanical tx x45 ice-estim light therapy as per protocol manual technique therapeutic exercise
[illegible] to well pt cont care
Signed: [illegible] PT
taping applied

◆ Date of Service: 11-9-09 (4/10)
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☐ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
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Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: mechanical tx x45 ice-estim light therapy as per protocol manual technique therapeutic exercise
[illegible] to well pt cont care
Signed: [illegible] PT

◆ Date of Service: 11-10-09 4/10
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
Rehab: ☒ Therapeutic Exercises 97110 ☐ Therapeutic Activities 97530 ☐ NMR 97112 ☐ Gait Training 97116 ☐ Aqua. Ther. 97113
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(See Rehab Flow Sheets)
Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: mechanical tx x45 ice-estim light therapy as per protocol manual technique therapeutic exercise
[illegible] to well pt cont care
Signed: [illegible] PT

◆ Date of Service: 11-12-09 (5/10) taping applied
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
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(See Rehab Flow Sheets)
Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: mechanical tx x45 ice-estim light therapy as per protocol manual technique therapeutic exercise
[illegible] to well pt cont care
Signed: [illegible] PT

taping applied

received on 12/7/2009 12:40:29 PM [Eastern Standard Time]

FROM : A-Z VIDEO FAX NO. : 7322704287 Dec. 07 2009 02:55PM P31

4 - 25

PHYSICAL THERAPY NOTES

Patient: Ralph Vanderende Number: ______ Page: ____

◆ Date of Service: 11-13-05 4/10
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
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Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: Mechanical tx x45 ice-estim light therapy as per protocol therapeutic exercise manual technique
Pt tol tx well Pt cont plan
Signed J. DeLorenzo PT
taping applied

◆ Date of Service: 11-16-05 5/10
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
Rehab: ☒ Therapeutic Exercises 97110 ☐ Therapeutic Activities 97530 ☐ NMR 97112 ☐ Gait Training 97116 ☐ Aqua. Ther. 97113
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(See Rehab Flow Sheets)
Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: Mechanical tx x45 ice-estim light therapy as per protocol therapeutic exercise
Pt tol tx well Pt cont plan
Signed J. DeLorenzo PT

◆ Date of Service: 11-17-05 4/10 taping applied HEP thera
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
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Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: Mechanical tx x45 ice-estim light therapy as per protocol manual technique therapeutic exercise
Pt tol tx well Pt cont plan
Signed J. DeLorenzo

◆ Date of Service: 11-24-05 6/10 taping applied
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☐ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
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(See Rehab Flow Sheets)
Assessment: ☐ PT Evaluation 97001 ☐ PT Re-Evaluation 97002 ☐ Manual Musc. Test 95831 ☐ Inclinometry 95851 ☐ FCE 97750
Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: Mechanical tx x45 ice-estim light therapy as per protocol manual technique therapeutic exercise
Pt tol tx well Pt cont plan
Signed J. DeLorenzo PT

◆ Date of Service: 12-1-05 taping applied 6/10
Subjective: Patient states there is: ☒ Pain ☐ Spasm ☒ ROM Restricted ☒ Weakness ☐ ADL Difficulties ☐ Radicular Symptoms
Objective: Patient demonstrates: ☒ Pain ☐ Swelling ☐ Spasm ☒ ROM Restricted ☒ Decreased Strength ☐ Postural Deviation
Plan/Treatment: ☒ Hot/Cold 97010 ☐ Ultrasound 97035 ☒ Musc. Stim. 97014 ☐ Mechan. Traction 97012 ☒ Man. Therapy 97140
Rehab: ☒ Therapeutic Exercises 97110 ☐ Therapeutic Activities 97530 ☐ NMR 97112 ☐ Gait Training 97116 ☐ Aqua. Ther. 97113
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Therapy Tolerated: ☒ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Medical Re-evaluation ☐ Discharged
Note: Mechanical tx x45 ice-estim light therapy as per protocol manual technique therapeutic exercise
Pt tol tx well Pt cont plan
Signed J. DeLorenzo PT

taping applied

received on 12/7/2009 12:40:29 PM [Eastern Standard Time]

SAMUEL D. SCHENKER, M.D., L.L.C., D.A.A.P.M.
NEUROLOGIST
DIPLOMATE AMERICAN ACADEMY OF PAIN MANAGEMENT
SPECIALIZING IN MEDICAL AND INTERVENTIONAL PAIN MANAGEMENT
388 LAKEHURST ROAD
TOMS RIVER NEW JERSEY 08755
(732) 341-2822
(732) 341-7087 fax

RE: VANDEVENTER, RALPH
PROGRESS NOTE: 11/20/09

The patient is seen here at this time for evaluation of his history of lumbosacral radiculopathy with associated herniated disc on the right. The patient has done extremely well post injection. He has good range-of-motion with minimal discomfort. At this juncture, the left side demonstrates facet pain at L3-L4, L4-L5 and L5-S1 with limitation of rotation of the torso and associated referred pain into the upper thoracic region. At this time, the patient will be scheduled for L4-L5 facet block the following week.

Samuel D. Schenker, M.D.

SDS/jmv
typed but not proofread
DOC: VANDEVENTER.R8.
DD: 11/20/09
DT: 11/23/09

SAMUEL D. SCHENKER, M.D.
NEUROLOGIST
DIPLOMATE AMERICAN ACADEMY OF PAIN MANAGEMENT
SPECIALIZING IN MEDICAL AND INTERVENTIONAL NEUROLOGY
388 LAKEHURST ROAD
TOMS RIVER NEW JERSEY 08755
(732) 341-2822
(732) 341-7087 fax

Patient's Name: Vandeventer, Ralph

Date of Surgery: 11/25/09

Preoperative Diagnosis: Facet Syndrome

Postoperative Diagnosis: Facet Syndrome

Procedure: Left facet injection under fluoroscopic guidance, L4-5. #1

Anesthesia: Local

Preoperative Note: The patient was made aware of the risks and benefits of the procedure and essentially accepts the conditions.

Operative Note: The patient was brought into the operating theater where he was placed decubitus prone and prepped in the standard sterile fashion.

After good visualization under fluoroscopy, localization of the left L4-5 facet joint was made with 1 cc of 1% Xylocaine and a 25 gauge, 1.5 inch needle. Placement of a 25 gauge, 3.5 inch needle was directed into that localization without any difficulty with L4-5 on the left. An injection of 40 mg of Depo-Medrol, 1 cc of Xylocaine 1% and 1 cc of 0.5% Marcaine was injected into said joint. The needle was extracted, and pressure was applied in that distribution with assistance.

received on 12/7/2009 12:40:29 PM [Eastern Standard Time]

Patient's Name: Vandeventer, Ralph
Performed on: 11/25/09
Page Two

Postoperative: The patient demonstrated a good response to said injection without any untoward effects. The patient demonstrates good cognitive status and is discharged from this office on his own cognizance.

Samuel D. Schenker, M.D.

SDS/jmv
typed but not proofread
DOC: VANDEVENTER,R9.
DT: 11/25/09

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Ralph R Van Deventer Jr

[redacted]

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 11/13/09

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7007 0710 0003 1698 3815

PS Form 3811, February 2004 Domestic Return Receipt JS 102595-02-M-1540

ReedGroup
15 Tech Valley Drive
2nd Floor, Suite 3
East Greenbush, New York 12061

November 12, 2009

Ralph R. Van Deventer Jr.
[redacted]

Case #: 74518
WWID#: 10900

Dear Ralph Van Deventer Jr:

Based on the provisions of the Johnson and Johnson Long Term Disability (LTD) Plan, you are required to file for Social Security Disability Insurance (SSDI) before, at, or within a reasonable period after, the end of your twenty-six (26) weeks of Short Term Disability.

Per the Plan requirement, the following information needs to be submitted to Reed Group within 30 days:

- Proof of SSDI filing prior to denial letter, or
- Explanation of extenuating circumstances as to why filing was not completed as required

Please provide the requested information by 12/12/2009. If this information is not received, your LTD benefits will be terminated effective 12/12/2009.

If you have any questions or concerns regarding your LTD claim, please call us at (866) 829-8861.

Thank You,

Reed Group

cc: Corporate Benefits

ReedGroup
15 Tech Valley Drive
2nd Floor, Suite 3
East Greenbush, New York 12061

November 9, 2009

Ralph R Van Deventer Jr
[redacted]

Case #: 74518
WWID#: 10900

Dear Ralph R Van Deventer Jr:

Reed Group is the administrator for Johnson & Johnson's Long Term Disability (LTD) Plan. As you know, you have been on an approved LTD status since 3/9/2009 and we would like to take this opportunity to provide you with some information relative to your LTD status. The LTD Plan under which you are currently on an approved LTD status contains the following definitions of Total Disability that states:

For periods of disability beginning on or after July 1, 2004, the term "Total Disability" or "Totally Disabled" means

(a) *during the Elimination Period, the complete inability of the Participant, due to Sickness or Injury to perform the Essential Functions of his or her Regular Occupation, with or without reasonable accommodation, AND*

(b) *during the portion of any period of disability not exceeding 12 months following the duration of the Elimination Period, the complete inability of the Participant, due to Sickness or Injury, to perform the Essential Functions of his or her Regular Occupation, with or without reasonable accommodation; AND*

(c) *during the remainder, if any, of the period of disability, the complete inability of the Participant, due to Sickness or Injury, to perform* ***any job*** *for which the Participant is (or may reasonably become) with or without reasonable accommodation qualified by training, education or experience.*

A review of our records indicates that the initial period of benefits as defined in part (b) will end on 3/9/2010. After this date, you must be Totally Disabled as defined in part (c) above. We will be conducting a thorough evaluation of your claim to determine your eligibility for benefits beyond this date.

Enclosed please find an Attending Physician Statement, Physician Contact Sheet, a Release to Work Form and a Medical Authorization Form. Please have your current treating providers complete these forms as well as provide the following supporting documentation:

- A copy of the medical reports, office records; including dictations, progress and therapy notes for the past 1 month
- Current treatment plan, including medication and therapy schedules from your treating physicians for the past 1 months
- Any recent diagnostic testing reports for the past 1 months

ReedGroup

All of the above requested information must be returned within thirty (30) days from the date of this letter.

Please note that it is ultimately your responsibility to ensure all your treating physicians provide us with the requested information to evaluate your current medical status and continued eligibility for Plan benefits. If this information is not received as requested, your LTD benefits will be terminated.

Johnson and Johnson or Reed Group will not incur any expense in procuring medical evidence and/or records necessary in the evaluation of your disability claim. Any fee associated with providing this information is solely your responsibility.

If you have any questions or concerns regarding this matter, please contact us at (866) 829-8861.

Thank You,

Christin Clark
Reed Group

cc: Corporate Benefits

ReedGroup

ATTENDING PHYSICIAN STATEMENT (Page 1 of 2)

NOTE TO PHYSICIAN OR OTHER HEALTH CARE PROVIDER: Your full completion of this form is necessary so that the claimant's application for benefit may be received and processed. Space is available on the reverse side if you wish to amplify your answers.

PLEASE ANSWER ALL QUESTIONS. RETURN FORM TO REED GROUP PROMPTLY. Fax #: 518-880-6610

Name of patient _____ Date of birth ____/____/____ (Mo. / Day / Year)

Employer name _____

1. HISTORY
   (a) When did symptoms first appear or accident happen? Mo._____ Day_____ Year_____
   (b) Date patient ceased work because of disability Mo._____ Day_____ Year_____
   (c) Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes" state when and describe:
   (d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
   (e) Names and addresses of other treating physicians:

2. DIAGNOSIS (including primary and secondary diagnoses or complications)
   (a) Diagnosis: _____
   (b) Date of last examination Mo._____ Day_____ Year_____
   (c) Subjective symptoms:
   (d) Objective findings: Your patient may be covered under the Long Term Disability (LTD) provisions of the Johnson and Johnson Plan. To assist Reed Group in making this difficult determination, we request your cooperation in forwarding the yield of objective tests already taken (for example, electrocardiograms, angiograms, etc. for a heart condition; vital capacity readings for emphysema; x-rays for muscular skeletal disorders) and the results found through the use of other clinical techniques.
   Do you wish this information returned? ☐ Yes ☐ No

3. DATES OF TREATMENT
   (a) Date of first visit Mo._____ Day_____ 20____
   (b) Date of last visit Mo._____ Day_____ 20____
   (c) Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify)

4. NATURE OF TREATMENT (including surgery and medications prescribed, if any)

5. PROGRESS
   (a) Has patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
   (b) Is patient ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?
   (c) Has patient been hospital confined? ☐ Yes ☐ No
   If "Yes," give Name and Address of Hospital _____
   Continued from _____ through _____

6. CARDIAC (if applicable)
   (a) Functional capacity (American Heart Ass'n.) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)
   (b) Blood Pressure (last visit) _____/_____ (SYSTOLIC / DIASTOLIC)

ReedGroup

ATTENDING PHYSICIAN STATEMENT (Page 2 of 2)

7. PHYSICAL IMPAIRMENT

- ☐ Class 1 — No limitation of functional capacity; capable of heavy physical activity. No restrictions. (0-10%)
- ☐ Class 2 — Slight limitation of functional capacity; capable of light manual activity. (15-30%)
- ☐ Class 3 — Moderate limitation of functional capacity; capable of clerical administrative (sedentary) activity. (35-55%)
- ☐ Class 4 — Marked limitation. (60-70%)
- ☐ Class 5 — Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)
- ☐ Remarks:

8. MENTAL/NERVOUS IMPAIRMENT (if applicable)

- ☐ Class 1 — Patient is able to function under stress and engage in interpersonal relations (no limitations)
- ☐ Class 2 — Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ☐ Class 3 — Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4 — Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5 — Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
- ☐ Remarks:

Do you believe patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

9. PROGNOSIS

	PATIENT'S JOB	ANY OTHER WORK
(a) Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
(b) Do you expect a fundamental or marked change in the future?	☐ Yes ☐ No	☐ Yes ☐ No
(1) If "Yes," when will patient recover sufficiently to perform duties	____/____/____ Mo. Day Yr. ☐ 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mos. ☐ Never	____/____/____ Mo. Day Yr. ☐ 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mos. ☐ Never

(2) If "No," please explain:

10. REHABILITATION

	PATIENT'S JOB	ANY OTHER WORK
(a) Is patient a suitable candidate for trial employment?	☐ Yes ☐ No	☐ Yes ☐ No
(1) If "Yes," when could trial employment commence?	____/____/____ Mo. Day Yr. ☐ 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mos. ☐ Never	____/____/____ Mo. Day Yr. ☐ 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mos. ☐ Never

(2) If "Yes," what training will patent require?
(3) If "Yes," what type of employment would you suggest?
(4) If "No," please explain:

11. REMARKS

Physician's Signature _____ Date _____

Name (Attending Physician) Print _____ Degree _____ Telephone _____

Street Address _____ City or Town _____ State of Province _____ Zip Code _____

Claimant Full Name _____ WWID#: _____

Please Fax to 518-880-6610 or Mail to the Address Listed Below

ReedGroup

AUTHORIZATION TO DISCLOSE AND USE MEDICAL INFORMATION FOR DISABILITY-RELATED DETERMINATIONS

Claimant's Full Name_____ Date of Birth:_____

Employer's Name: Johnson & Johnson Social Security Number (last 4 digits only): xxx-xx-_____

I authorize all doctors, hospitals, other health care providers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out my medical information as explained on this form.

This Information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, expenses, coverage or benefits, or my employment, vocation, education, training, or income, relating to my current disability or my ability to work, whether obtained prior to or after the date of this authorization ("Information").

Information may be provided to the following individuals or entities ("Benefit Managers"): the employer named above, Reed Group, their benefit plan or claims administrator(s), their related companies, contractors, investigators, attorneys, and service consultants, health care providers who treat or evaluate me with respect to my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim, to allow them to evaluate, analyze, manage and/or administer my claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program or leave benefit offered by and through my employer ("Benefits Program"), to support, defend, or review any determinations made with respect to the programs and benefits and to give my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim under a Benefits Program, or to run a Benefits Program. The Benefits Managers will tell those receiving the Information that the Information is confidential.

I understand that once my Information is given out as authorized in this form, federal privacy laws may not protect it. Benefits Managers may give Information out again as described in this form.

I understand that this permission lasts twelve (12) months after my claim and all appeals are processed or twelve (12) months after the end of my coverage or benefits under the Benefits Program, whichever is longer, unless the law requires a shorter period. If I change my mind before that time, I can tell Reed Group in writing that I do not want Record Holders or Benefit Managers to share any more information. If I write to stop them from sharing information, it will not change any actions they took before they receive my letter.

If I do not sign this form, it will not affect how my health care providers treat me. However, if I do not sign, the Benefits Managers may not be able to review my claim and find out whether I am eligible for benefits. This may result in the delay or denial of my request for benefits.

The Information released under this authorization can be sent electronically, by phone or fax, or by mail. I know I can see or request a copy of the records given to the Benefits Managers. I agree that a copy of this form may be treated as a signed original. I understand the terms of this form.

_____ _____

Claimant's or Legal Representative's Signature Date

_____ _____

Legal Representative's Name (if any) Legal Representative's Relationship

The person or entity disclosing the Information is responsible for deciding whether to accept this authorization form and, on acceptance, shall send a copy to the claimant.

Please Fax to Reed Group at 518-880-6610 or Return by Mail to the address listed below

Confidential
Admin Rec. 00301

ReedGroup

Release to Work Form

Instructions: Prior to returning to work from a Long Term Disability (LTD) **with or without temporary restrictions**, you **MUST** fax this form to Reed Group at 518-880-1910 for approval.

If you have any questions, please call 866-829-8861.

Part I - To be completed by Claimant	
Claimant Name: (Please Print)	Worldwide ID #:

Part II - To be completed by Medical Provider – Please do NOT list diagnosis or nature of illness/injury

I certify that this individual is medically fit to return to work on (date): _____

The individual's medical condition ☐ **will** (Please complete Part III) OR ☐ **will not** (skip to Part V) impact his/her ability to perform all of the essential functions of any occupation that his/her training, experience and education will allow him/her to perform, or for which he/she may reasonably become qualified with or without reasonable accommodation.

If temporary accommodation(s) are necessary, the projected full duty release is (date): _____

Part III – Abilities – To be completed by Medical Provider

Identify appropriate work level for claimant's condition:

☐ SEDENTARY WORK – Sitting most of the time; brief periods walk/stand; lift up to 10 lbs. occasionally

☐ LIGHT WORK – Significant degree of walking/standing; some sitting; lift - up to 20 lbs. occasionally

☐ MEDIUM WORK – Lift up to 50 lbs. occasionally; 20 lbs. frequently; 10 lbs. constantly

☐ HEAVY WORK – Lift up to 100 lbs. occasionally; 50 lbs. frequently; 20 lbs. constantly

☐ VERY HEAVY WORK – Lifting in excess of 100 lbs. occasionally; 50 lbs. frequently; 20 lbs. constantly

ACTIVITY	NONE	OCCASIONALLY (1-to-3-hours)	FREQUENTLY (3-to 6 hours)	CONTINUOUSLY (6 + Hours)
Stand/Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Drive	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Grasp	☐	☐	☐	☐
Push/Pull	☐	☐	☐	☐
Reach	☐	☐	☐	☐

ReedGroup

Claimant Name: (Please Print)	Worldwide ID #:

Part IV – Temporary Restrictions

This individual may return to work with the following temporary restrictions:

RESTRICTION	DATE RESTRICTION BEGINS	DATE RESTRICTION END

Part VI – Medical Provider Information

Attending Physician's Name: (Please Print)	Attending Physician's Phone Number:
Attending Physician's Signature:	Date:

Please Fax to Reed Group at 518-880-6610 or Return by Mail to the address listed below

ReedGroup

Physician Contact Sheet

Directions – Please FAX to 518-880-6610. If you have any questions, call Reed Group at 866-829-8861.

Claimant Name (Please Print):	WWID#:	Claimant Phone Number:
Physician Contact #1		
Physician Name/Specialty:	Physician Phone Number:	Fax Number:
Street Address:	City:	State:	Zip Code:
Date of Last Visit (MM/DD/YYYY):	Date of Next Visit (MM/DD/YYYY):	
Physician Contact #2		
Physician Name/Specialty:	Physician Phone Number:	Fax Number:
Street Address:	City:	State:	Zip Code:
Date of Last Visit (MM/DD/YYYY):	Date of Next Visit (MM/DD/YYYY):	
Physician Contact #3		
Physician Name/Specialty:	Physician Phone Number:	Fax Number:
Street Address:	City:	State:	Zip Code:
Date of Last Visit (MM/DD/YYYY):	Date of Next Visit (MM/DD/YYYY):	

[ ] **I am no longer disabled** - Effective Date: _____
Month Day Year

Name of treating provider providing medical release (Print):_____

FROM : A-Z VIDEO FAX NO. : 7322704287 Oct. 06 2009 12:54PM P1

FAX

To: Christin Clark
Fax: 518-880-6610

# of pages including cover sheet: 3
Date: 10/06/09

From: Ralph Van Deventer
Phone: [redacted]
Cell: [redacted]

Re: Case # 74518

Dear Christin,

Please find attached to this fax the required items that you requested today. They are:
1. Neurologist/Pain Management office note from 09/18/09.
2. Orthopedist office note from 09/21/09.

If there are any questions or you need anything else, please let me know. You can contact me at the above phone numbers. Thank you.

Sincerely,

received on 10/6/2009 12:01:38 PM [Eastern Daylight Time]

SAMUEL D. SCHENKER, M.D., L.L.C., D.A.A.P.M.
NEUROLOGIST
DIPLOMATE AMERICAN ACADEMY OF PAIN MANAGEMENT
SPECIALIZING IN MEDICAL AND INTERVENTIONAL PAIN MANAGEMENT
388 LAKEHURST ROAD
TOMS RIVER NEW JERSEY 08755
(732) 341-2822
(732) 341-7087 fax

RE: VANDEVENTER, RALPH
PROGRESS NOTE: 09/18/09

The patient is seen here at this time status post cervical facet injections. The patient has done extraordinarily well at this juncture with the cervical spine, but he still has residual lumbosacral pain. The patient has no symptoms with regard to the cervical spine at this time and is moderately improved. The patient does, however, have pain in the lumbosacral region, predominantly on the right side, with evidence on MRI of L4-L5 herniation. The patient was, however, given facet blocks by Dr. Quinones which did not work in any format since the patient did not receive any steroids in those facet joints. Otherwise, the patient has a positive straight-leg-raise and will be scheduled the following week for transforaminal epidural injection.

Samuel D. Schenker, M.D.

SDS/jmv
typed but not proofread
DOC: VANDEVENTER,R6.
DD: 09/18/09
DT: 09/21/09

RALPH VANDEVENTER

DOB [redacted]

9-21-09

HISTORY: Patient has been declared disabled. He had an Independent Medical Examination whereupon home exercises were recommended as well as anti-inflammatory medication. I gave him a prescription for physical therapy once a week for three weeks to teach him a home exercise program to both his neck and back. As far as anti-inflammatory medication is concerned, it is my opinion that he should take over-the-counter anti-inflammatory medication on a prn basis and not on a regular basis.

RETURN: Only as necessary.

IDS:pb

FAX

To: Christin Clark
Fax: 518-880-6610

# of pages including cover sheet: 11
Date: 10/01/09

From: Ralph Van Deventer
Phone: [redacted]
Cel[redacted]

Re: Case # 74518

Dear ,

Please find attached to this fax the required items that you listed in your 09/14/09 letter. They are:

1. A script from my Pain Management doctor for a non-steroidal anti-inflammatory medication. He prescribed Celebrex.
2. A script from my Orthopedist doctor for my Physical therapist to issue a home exercise program.
3. The Physical Therapist evaluation/recertification office notes.
4. Copy of the home exercise program.

If there are any questions or you need anything else, please let me know. You can contact me at the above phone numbers. Thank you.

Sincerely,

Ralph Van Deventer

State of New Jersey
PRESCRIPTION BLANK

SAMUEL D. SCHENKER, M.D., L.L.C.
NEUROLOGY
338 LAKEHURST ROAD
TOMS RIVER, NJ 08755
732-341-2822 FAX: 732-341-7087
DEA # _____ NPI # 1750327326 LIC # 25MA04118800
BATCH #TRI090728100098492-98 SERIAL # 000280

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE ☐
AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT Ralph Vanderveen D.O.B.

ADDRESS DATE 9/18/09

Rx

Celebrex
200 mg
#30

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER

REFILL _____ TIMES

Use separate form for each controlled substance prescription

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW

IRVING D. STROUSE, M.D., P.A.

ORTHOPEDIC SURGERY

DATE 9/24/09

SUITE 604
279 THIRD AVENUE
LONG BRANCH, NJ 07740
(732) 229-4333

4686 ROUTE 9 NORTH
HOWELL, NJ 07731
(732) 370-4600

PATIENT: Ralph Vandeventer

DIAGNOSIS: Cervical & Lumbar
deg disk disease

RX: 1 TIMES PER WEEK FOR: 3

RETURN TO DR:

[-] EVALUATE Trial Home

[ ] SET UP THERAPY PROGRAM

[ ] CONTINUE

[ ] CHANGE Exercise Program

[ ] BACK [ ] NECK [ ] HIP [ ] KNEE [ ] ANKLE

[ ] FOOT [ ] ELBOW [ ] WRIST [ ] HAND [ ] RIBS

[ ] SHOULDER [ ] OTHER

IRVING D. STROUSE, M.D.